Peer Support Program Application

Richmond Mental Health
Consumer and Friends' Society (RCFC)

210-7671 Alderbridge Way, Richmond, BC V6X 1Z9
Ph: (604) 675-3977 Fax (604) 214-0947

Peer Support Program
Participant Information

Name: ___________________________________

Address: ____

Phone: ____________________ Birth date: ____________ Medical Services Plan # ______________

<u>Persons to be contacted in case of an emergency</u>

	Name Please Print	**Phone**
Relative/partner:	______________________	______________________
Family Doctor:	______________________	______________________
Psychiatrist:	______________________	______________________
Mental Health Worker:	______________________	______________________
Other:	______________________	______________________

Allergies: (Please list all known allergies, including food, insect bites, vegetation etc <u>and</u> their effects)

Physical Health: (Please list any health considerations pertinent to leisure activity and exercise. Eg: diabetes, physical injuries or limitations, seizures, high blood pressure, ect)

Environmental "Stressors" (Please describe any situations or environmental stimuli which may cause undue stress, anxiety or fear etc and therefore should be avoided.)

Medications: (Please list all medications and what they are for. Eg: insulin for diabetes)

Peer Support Program
Acknowledgement and Consent

By signing below, I acknowledge that to the best of my knowledge the information provided on this form is complete and accurate, and will be kept in secure confidence by the Peer Support Workers and Staff employed by Richmond Mental Health Consumer & Friends Society.

I further understand and accept that the program is expressly for adults in recovery from a mental illness with no recent history of unsafe behavior, and that my ongoing **voluntary** participation may be conditional on corroboration of that diagnosis by my doctor or mental health professional.

I further understand and agree that in the event of a psychiatric, medical or other emergency situation the information will be provided to third parties only as RCFC staff deem necessary for my safety and care.

NAME Please Print **Signature**

Participant: ______________________________ ______________________________

Witness: ______________________________ ______________________________

Date signed: ______________________________ ______________________________

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CONSENT FOR RELEASE OF INFORMATION FORM

Richmond Mental Health Consumer and Friends Society (RCFC), respects and upholds an individual's right to privacy. In order to safeguard client confidences, RCFC acts within the constraints of the law and policies of the Richmond Health Services, and have attached their brochure about the "Freedom of Information and Protection of Privacy Act".

Please note that in order to determine eligibility, mental readiness and safe behavior within a group or community setting, it may be necessary to contact the professional and discuss and/or receive information about you. Please indicate your consent to this process below. Your information will be maintained as a confidential, secure record.

For the purposes stated above, I, ____ (print)
give consent to authorized representatives of Richmond Mental Health Consumer and Friends Society, to contact:

Name: ________________________________ Title: _________________________________

Address: ____

Phone: ________________________________ Fax: ______________________________

This consent from remains valid for the duration of the individual's participation in the program up to one year from the date signed.

Date: ________________________________ Signed: ______________________________

Date: ________________________________ Witness: _____________________________
(Indicate: Physician, Mental Health Professional, or RCFC Staff)

REFERRAL FORM
For RCFC Programs
(to be completed by Physician or Mental Health Professional)

Name of Client being Referred to RCFC:						
Physician or Mental Health Professional in case of an emergency:					Telephone Number:	
Client has been diagnosed with a Mental Health Condition by a doctor or psychiatrist					Yes:	No:
History of Physical Aggression	Yes	No	N/K	If yes, please describe, with date of the last known incident:		
Other behavior(s) That may pose a safety risk	Yes	No	N/K	If yes, please describe, with date of the last known incident:		
Given what you know about your client, do you feel he/she is ready at this time to participate with other peers, either at the mental health TEAM or in the community?						
If incidents (above) have been minor, do you have any recommendations on how these can best be prevented?						
Please specify goals or activities to be accomplished						
Your name (print):				Signature:		
Title/position:				Date:		

All information obtained shall be kept in the strictest confidence with RCFC in a securely locked cabinet in accordance with the "Freedom of Information and Protection of Privacy Act"